Submitter : Dr. Michele Freeman **Date:** 11/01/2006

Organization : Dr. Michele Freeman

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae.

The inclusion of CPT codes 35475, 35476, 36205 and 37206 to the list of Medicare approved ambulatory surgical center (ASC) procedures would provide Medicare the opportunity to reduce the cost of, and promote quality outcomes for, end-stage renal disease (ESRD) patients through more thoughtful reimbursement and regulation of vascular access procedures.

Submitter : Mr. Kenneth Camerota **Date:** 11/01/2006

Organization : New England Eye Surgical Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

We are an ASC that has been a Medicare provider since 1985.
We strongly object to the proposed CY2008 payment rates.
(1)the majority of our operating budget is personnel. In order to continue to provide care our personnel costs are the same as area hospitals.
(2)our costs to purchase capital equipment is often greater than the hospitals who buy larger amounts of capital equipment.

(3) If medicare lowers its ASC reimbursement, other payors will follow suite.

If this new payment system is allowed to pass the impact on ASC's will be (a) fewer will open, (b) several will close.

Please reconsider the overall impact on patient access to quality care.

Submitter : Ms. Lisa Marshall **Date:** 11/01/2006

Organization : North Shore Cataract and Laser Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

We are an ASC that has been a Medicare provider since 2002. We strongly object to the proposed CY2008 payment rates. (1)the majority of our operating budget is personnel. In order to continue to provide care and attract personnel our personnel costs are the same as area hospitals. (2)our costs to purchase capital equipment is often greater than the hospitals who buy larger amounts of capital equipment. (3) If medicare lowers its ASC reimbursement, other payors will follow suite. If this new payment system is allowed to pass the impact on ASC's will be (a) fewer will open, (b) several will close. Please reconsider the overall impact on patient access to quality care.

Submitter : Mrs. Callie Gryzwa **Date:** 11/01/2006

Organization : Aurora Medical Group Marinette Dialysis

Category : Nurse

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I feel that patients are safe to have outpatient fistula/graft/catheter placements in an outpatient surgical center. We have had many patients have this done in the past with no problems. It is up to the physicians to determine whether or not the procedure is safe for a particular patient. All patients are looked at individually and if they do not feel that the patient is safe to have the procedure done in an ASC then they do the procedure at the local hospital and the patient stays overnight for observation.

Submitter : Dr. Anthony Johnson **Date:** 11/01/2006

Organization : Jervey Eye Center, LLC

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See attached file

CMS-1506-P2-649-Attach-1.DOC

#6619

October 30, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services **ATT: CMS-1506-P**
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, NW
Washington, DC 20201

To Whom It May Concern:

I am writing in hopes of influencing the payment methodology for ambulatory surgery centers being discussed at present. As the Medical Director of Jervey Eye Center, LLC, I have seen an incredibly positive impact on our community with emphasis on the Medicare age group. Our ASC has been in operation since March 1999, and we have performed an average of 3,800 procedures per year which have been primarily cataract surgeries. In addition, we have also performed retinal procedures, ophthalmic plastic procedures, glaucoma procedures, and corneal transplantation procedures. Approximately 70 percent of our patients are Medicare beneficiaries. We take great pride in the incredibly low complication rate of our center, and we have accomplished our success without cutting any corners including anesthesia services. We employ both an anesthesiologist as well as certified registered nurse anesthetists who are involved in every single case. We have been able to save our patient beneficiaries a significant sum of money compared to these same services had they been performed in the outpatient surgery center of either one of our community hospitals. Our community hospitals have benefited by not having their outpatient schedule burdened by these procedures which have not been very fiscally beneficial to them in the past, so they have been able to open their schedule up to other more profitable services. All in all, this has been a win for the patient primarily, and it has also been a win for the community hospitals as well as to the doctors in our practice.

I am also interested in the ASC procedure list remaining too restrictive. The decision for the slightest surgery should be made by the surgeon in consultation with the patient. The ASC should be permitted to furnish and receive facility reimbursement for any procedures that are performed in the hospital outpatient departments as long as deemed safe by the surgeon performing the surgery.

The proposed payment of 62 percent of the hospital outpatient department payment rate is inadequate to meet the costs of providing these services. We compete for the same highly skilled nursing and anesthesia caregivers, and these supply costs are likely greater than the costs at the hospital outpatient departments simply because of their buying power. The agency should interpret the budget neutrality provision to permit ASCs to be paid at a rate of 75 percent of hospital outpatient departments, and this should apply to all ASCs regardless of their specialty type.

The annual update of payment rates should be a consistent index for both hospital outpatient departments as well as ASCs since the rate of cost increases should be similar for both. Therefore, I would propose that both facility types have their payment rates indexed to the hospital market basket (HMB).

Thank you for your interest and willingness to read my above concerns. Please do not hesitate to contact me if you have any questions.

Sincerely yours,

Anthony P. Johnson, M.D.
President and Managing Partner
Jervey Eye Group, P.A.
Medical Director, Jervey Eye Center, LLC

APJ/lmj

Submitter : Dr. Harold Shaw **Date:** 11/01/2006

Organization : Jervey Eye Center, LLC

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See attached file

CMS-1506-P2-650-Attach-1.DOC

#650

October 30, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services **ATT: CMS-1506-P**
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, NW
Washington, DC 20201

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Sincerely yours,

H. E. Shaw, Jr.

Harold E. Shaw, Jr., M.D.

HES/lmj

Submitter : Dr. Donald Shelley **Date:** 11/01/2006

Organization : Jervey Eye Center, LLC

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See attached file

CMS-1506-P2-651-Attach-1.DOC

#651

October 30, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services **ATT: CMS-1506-P**
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, NW
Washington, DC 20201

To Whom It May Concern:

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Thank you for your interest and willingness to read my above concerns. Please do not hesitate to contact me if you have any questions.

Sincerely yours,

Donald W. Shelley

Donald W. Shelley, M.D.

DWS/lmj

Submitter : Dr. Mark Cook **Date:** 11/01/2006

Organization : Jervey Eye Center, LLC

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See attached file

CMS-1506-P2-652-Attach-1.DOC

#1652

October 30, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services **ATT: CMS-1506-P**
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, NW
Washington, DC 20201

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Thank you for your interest and willingness to read my above concerns. Please do not hesitate to contact me if you have any questions.

Sincerely yours,

M. H. Cook, M.D.

Mark H. Cook, M.D.

MHC/lmj

Submitter : Dr. John Siddens **Date:** 11/01/2006

Organization : Jervey Eye Center, LLC

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See attached file

CMS-1506-P2-653-Attach-1.DOC

#653

October 30, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services **ATT: CMS-1506-P**
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, NW
Washington, DC 20201

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Thank you for your interest and willingness to read my above concerns. Please do not hesitate to contact me if you have any questions.

Sincerely yours,

John D. Siddens, D.O.

JDS/lmj

Submitter : Mrs. Suzanna Majewski **Date:** 11/01/2006

Organization : Bedford Ambulatory Surgical Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Unlisted Procedures

ASC Unlisted Procedures

As technology leaps ahead, more advanced procedures are constantly being developed and performed, requiring the use of unlisted procedure codes. HOPDs are paid for these services, ASCs are not. This again incentivizes the surgeon to bring these cases to the (often inappropriate) hospital setting. ASCs typically purchase high tech equipment that is not available in the hospital setting. The end result is that Medicare beneficiaries do not receive the highest level of care available, and at a higher cost to the patient and the government.

CY 2008 ASC Impact

CY 2008 ASC Impact

The ASC industry is requesting that fair and reasonable payment rates be established to allow Medicare beneficiaries and the government to save money on procedures that are safely and cost-effectively performed in the outpatient setting. At this time the proposed rates are inadequate and will result in many (mostly single specialty) ASCs to close their doors. We strenuously and respectfully request the methodology be simplified and the rates be reevaluated. If they are not, surgeons will be incentivized to bring high cost procedures to the more expensive hospital setting.

Submitter : Dr. C. Blake Myers **Date:** 11/01/2006

Organization : Jervey Eye Center, LLC

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See attached file

CMS-1506-P2-655-Attach-1.DOC

#655

October 30, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services **ATT: CMS-1506-P**
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, NW
Washington, DC 20201

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The annual update of payment rates should be a consistent index for both hospital outpatient departments as well as ASCs since the rate of cost increases should be similar for both. Therefore, I would propose that both facility types have their payment rates indexed to the hospital market basket (HMB).

Thank you for your interest and willingness to read my above concerns. Please do not hesitate to contact me if you have any questions.

Sincerely,

C. Blake Myers, M.D.

CBM/lmj

Submitter : SHANNYN SERFOZO **Date:** 11/01/2006

Organization : ATLANTA SURGERY CENTERS

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

I am the administrator for a single specialty surgery center in Marietta, Georgia, specializing in pain medicine. We serve a much needed patient population, that have a hard time getting care in a hospital setting. Many hospitals see pain medicine as 'small potatos' and do not want to dedicate the space or time or resources for providers to see these patients in a timely manner. Surgery centers provide the much needed SAFE space for providers to treat these patients. The proposed new payment rules are punishing the surgery center for being able to treat these patients, but greatly reducing the reimbursement and only allowing basically 1 year in order to prepare for this cut!
Hospitals repeatedly 'bump' pain cases for what they see as more important cases. Surgery centers such as ours provide the much needed space, time, and resources for patients to be treated without being 'bumped' for a different type of case. The greatly reduced reimbursement that is being proposed would make it very difficult for surgery centers like ours to continue to offer this very important care for these patients.
And to think that a surgery center would have basically 1 year to have to downsize to prepare for this is unacceptable.
Please consider the amounts you are proposing in addition to the time effect.

Submitter : Mrs. Lynette Ewy **Date:** 11/01/2006

Organization : Nueterra Healthcare

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mr. Clay Fowler **Date:** 11/01/2006

Organization : Parkridge Surgey Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

see attachment

CMS-1506-P2-658-Attach-1.DOC

#658

November 1, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

Our Ambulatory Surgery Center is owned 51% by a non profit hospital system and 49% by individual physicians. We serve the midlands of South Carolina and perform over 280 surgeries per month across a broad range of specialties. We perform orthopaedic, eye, urology, gynecology, urology, podiatry, general, and plastic surgery procedures.

The experience of ASCs is a rare example of a successful transformation in health care delivery. Thirty years ago, virtually all surgery was performed in hospitals. Waits of weeks or months for an appointment were not uncommon, and patients typically spent several days in the hospital and several weeks out of work in recovery. In many countries, surgery is still like this today, but not in the United States.

Both today and in the past, physicians have led the development of ASCs. The first facility was opened in 1970 by two physicians who saw an opportunity to establish a high-quality, cost-effective alternative to inpatient hospital care for surgical services. Faced with frustrations like scheduling delays, limited operating room availability, slow operating room turnover times, and challenges in obtaining new equipment due to hospital budgets and policies, physicians were looking for a better way - and developed it in ASCs.

Physicians continue to provide the impetus for the development of new ASCs. By operating in ASCs instead of hospitals, physicians gain the opportunity to have more direct control over their surgical practices. In the ASC setting, physicians are able to

schedule procedures more conveniently, are able to assemble teams of specially-trained and highly skilled staff, are able to ensure the equipment and supplies being used are best suited to their technique, and are able to design facilities tailored to their specialty. Simply stated, physicians are striving for, and have found in ASCs, the professional autonomy over their work environment and over the quality of care that has not been available to them in hospitals. These benefits explain why physicians who do not have ownership interest in ASCs (and therefore do not benefit financially from performing procedures in an ASC) choose to work in ASCs in such high numbers.

Overview

The broad statutory authority granted to the Secretary to design a new ASC payment system in the Medicare Modernization Act of 2003 presents the Medicare program with a unique opportunity to better align payments to providers of outpatient surgical services. Given the outdated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems. Although the HOPD payment system is imperfect, it represents the best proxy for the relative cost of procedures performed in the ASC.

In the comments to follow, we focus on three basic principles:

- maximizing the alignment of the ASC and HOPD payment systems eliminate distortions between the payment systems that could inappropriately influence site of service selection,

- ensuring beneficiary access to a wide range of surgical procedures that can be safely and efficiently performed in the ASC, and

- establishing fair and reasonable payment rates to allow beneficiaries and the Medicare program to save money on procedures that can be safely performed at a lower cost in the ASC than the HOPD.

Alignment of ASC and HOPD Payment Policies

Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost data used to evaluate outpatient surgical services for Medicare beneficiaries. The benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law. While we appreciate the many ways in which the agency proposes to align the payment system, we are concerned that the linkage is incomplete and may lead to further distortions between the payment systems. Many policies applied to payments for hospital

outpatient services were not extended to the ASC setting, and these inconsistencies undermine the appropriateness of the APC relative weights, create disparities in the relationship between the ASC and HOPD payment rates, and embed in the new payment system site of service incentives that will cost the taxpayer and the beneficiary more than necessary.

There are many components of the regulation where a more complete alignment of the ASC and HOPD payment systems is appropriate. Below is an overview of the major areas where further refinement of the proposed rule is warranted. These issues are discussed in greater detail under the relevant section heading in the text to follow.

- **Procedure list:** HOPDs are eligible for payment for any service not included on the inpatient only list. The CMS proposal would limit a physician's ability to determine appropriate site of service for a procedure excludes many surgical procedures appropriate for the ASC setting.

- **Treatment of unlisted codes:** Providers occasionally perform services or procedures for which CPT does not provide a specific code and therefore use an unlisted procedure code identify the service. HOPDs receive payment for such unlisted codes under OPPS; ASCs should also be eligible for payment of selected unlisted codes.

- **Different payment bundles:** Several of the policies for packaging ancillary and other procedure costs into the ASC payment bundle result in discrepancies between service costs represented in the APC relative weight. For example, when HOPDs perform services outside the surgical range that are not packaged, they receive additional payments for which ASCs should also be eligible.

- **Cap on office-based payments:** CMS proposes to cap payment for certain ASC procedures commonly performed in the office at the physician practice expense payment rate. No such limitation is applied to payments under the OPPS, presumably because the agency recognizes the cost of a procedure varies depending on the characteristics of the beneficiary and the resources available at the site of service. We likewise believe this cap is inappropriate for the ASC and should be omitted from the final regulation.

- **Different measures of inflation:** CMS updates the OPPS conversion factor for annual changes in inflation using the hospital market basket; however, the agency proposes to update ASC payments using the consumer price index for all urban consumers. The market basket is a better proxy for the inflationary pressures faced by ASCs, as it is the measure used by the agency to update payments to hospitals providing the same services.

- **Secondary rescaling of APC relative weights:** CMS applies a budget neutrality adjustment to the OPPS relative weight values after they are recalibrated with new cost data each year. The agency proposes a secondary recalibration of the relative weights before they are used by ASCs. This secondary recalibration will result in annual and potentially cumulative variation between ASC and HOPD payments without any evidence that the cost of providing services has further diverged between settings.

- **Non-application of HOPD policies to the ASC.** Over the years, CMS has implemented through statutory or administrative authority numerous policies to support services in the HOPD, including additional payment for high-cost outliers, transitional corridor and hold-harmless payments to rural and sole-community hospitals, and payments for new technologies. While not all of these policies are appropriate for the ASC, surgery centers should be eligible to receive new technology pass-through payments.

- **Use of different billing systems:** The HOPD and ASC use the UB-92 and CMS-1500, respectively, to submit claims to the government for services. Use of different forms prevents ASCs from documenting all the services provided to a Medicare beneficiary, therefore undermining the documentation of case mix differences between sites of service. Most commercial payors require ASCs to submit claims using the UB-92, and the Medicare program should likewise align the payment system at the claim level.

Ensuring Beneficiaries' Access to Services

Ambulatory surgery centers are an important component of beneficiaries' access to surgical services. As innovations in science and technology have progressed, ASCs have demonstrated tremendous capacity to meet the growing need for outpatient surgical services. In some areas and specialties, ASCs are performing more than 50% of the volume for certain procedures. Sudden changes in payments for services can have a significant effect on Medicare beneficiaries' access to services predominantly performed in ASCs.

The implementation of the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs are typically focused on a narrow spectrum of services that require similar equipment and physician expertise, they have a limited ability to respond to changes in the payment system other than to adjust their volume of Medicare patients. On the one hand, for procedures such as ophthalmology, there is a limited market for these services in the non-Medicare

population. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean relocating their practice to the HOPD. Such a decision would increase expenditures for the government and the beneficiary. On the other hand, the demand for services such as diagnostic colonoscopies is extremely high in the non-Medicare population. If ASCs determine that the payment rates for such services are too low, they may be able to decrease the proportion of Medicare patients they see without reducing their total patient volume. In that case, beneficiaries may experience significant delays accessing important preventive services or treatment. Neither outcome is optimal for the beneficiary of the Medicare program.

Establishing Reasonable Reimbursement Rates

Medicare payment rates for ASC services have remained stagnant for nearly a decade. Over time, the industry has identified which services it can continue to offer to Medicare beneficiaries through reductions in cost and improvements in efficiency. In the Medicare Payment Advisory Commission's first review of ASC payments in 2003, ASCs were paid more than the HOPD for eight of the top ten procedures most frequently performed in the ASC. One suggestion by the commission was that services migrated to the ASC because the payment rate was higher than the HOPD. However, a multi-year payment freeze on ASC services has turned the tables and now the HOPD rate in 2007 will be higher (or the same) for eight of the same ten ASC procedures. The continued growth of ASCs during the payment freeze is a strong testament to their ability to improve their efficiency and the preference of physicians and beneficiaries for an alternative to the hospital outpatient surgical environment.

The impact of HOPD payments eclipsing the ASC rates has had the perverse effect of increasing the "cost" of the budget neutrality requirement imposed by the Medicare Modernization Act on the future conversion factor for ASC payments. The Lewin Group estimates that the inflation updates applied to the HOPD rates since passage of the MMA account for 40 percent of the discount required to achieve budget neutrality under the agency's proposed rule. This, combined with the agency's narrow interpretation of budget neutrality, produce an unacceptably low conversion factor for ASC payments.

- Budget Neutrality: Adopt an expansive, realistic interpretation of budget neutrality. The new payment system and the expansion of the ASC list will result in migration of services from one site of service setting to another. CMS has the legal authority and the fiduciary responsibility to examine the consequences of the new ASC payment system on all sites of care – the physician office, ASCs, and HOPD.

- By setting the proposed rates at 62% of HOPD, CMS would force doctors to move cases to the more expensive hospital setting, increasing the amount of money paid by Medicare beneficiaries and the government. Rather than paying ASCs a set percentage of HOPD rates, the proposed rule establishes a complicated formula to link ASC payment to HOPD payment but does not link payment in a uniform manner. This will impede Medicare beneficiaries' ability to understand their real costs in alternative settings. In the words of President Bush, Medicare beneficiaries need to be able to make "apples to apples" comparisons in order to increase transparency in the health care sector.

- CMS failed to include on the procedure list many higher complexity services that have for years been safely and effectively performed in ASCs throughout the country. By not creating a truly exclusionary list, CMS is losing an opportunity to increase patient choice and rely on the clinical judgment of the surgeon.

If you have comments or questions regarding this correspondence, please feel free to contact me.

Sincerely,

J. Clay Fowler, FACHE
Vice President and Administrator

Submitter : Clement Berry **Date:** 11/01/2006

Organization : Eyecare Medical Group

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Conversion Factor

ASC Conversion Factor

See attached

ASC Inflation

ASC Inflation

See attached

ASC Office-Based Procedures

ASC Office-Based Procedures

See attached

ASC Ratesetting

ASC Ratesetting

See attached

ASC Unlisted Procedures

ASC Unlisted Procedures

See attached

ASC Updates

ASC Updates

See attached

CMS-1506-P2-659-Attach-1.RTF

#659

October 26, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Norwalk:

As Chief Executive Officer of Eyecare Medical Group and a former Hospital Chief Executive Officer and Chief Financial Officer , I would like to comment on the Proposed Rule – DHHD, CMS, 42 CFR Parts 410, 414, et al: Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates, et al - published on Wednesday, August 23, 2006 in the Federal Register. Eyecare Medical Group is an ophthalmic ambulatory surgery center and clinic practice that strives for the highest quality of patient care in a cost effective manner. The major of our patients have Medicare for insurance.

PAYMENT RATES

To assure Medicare beneficiaries' access to ASCs, CMS should broadly interpret the budget neutrality provision enacted by Congress. The proposal that ASCs will receive 62% of the Hospital rate is not an adequate payment for these services. The real issue is comparing the costs of providing ambulatory surgery in a hospital outpatient setting versus an ASC. Whether a patient has outpatient surgery in a hospital or an ASC, the resources needed are the same - equipment, staff, medical supplies, drugs, etc. The cost differences for the resources are significant:

1. The costs for equipment, supplies and drugs are higher for ASCs because hospitals belong to large Group Purchasing Organizations and receive larger discounts for these items. Therefore, ASCs have higher costs for equipment, medical supplies and drugs.
2. Staffing costs for outpatient surgery is the same as we both compete for employees in the same market.
3. Facility overhead costs for hospitals are slightly higher than ASCs due to building standards. However, the facility costs for most hospitals are

significantly higher than ASCs due to the fact most Hospitals build facilities that are bigger and grander than other providers. Over the past seven years, the trend has been for Hospitals to build new hospitals, additions and major renovations to their facilities. The issue is the high cost of construction. These costs are high because requirements to meet life safety codes or improved patient care, but rather how the hospital can look like a five star hotel. This increases the cost of care for all.

4. The most significant cost difference is the cost per outpatient surgery case. ASCs can and do provide lower costs per case than hospitals. ASCs are the leaders in driving down the cost of medical care while providing high quality services. To survive financially, ASCs have been forced to provide effective and efficient care by changing processes, patient flow, turnover time, and reducing the waste of staff time and other resources. These changes have reduced the cost of health care for Medicare. On the other hand, my twenty years of hospital experience, including CEO and CFO positions, has shown me that change is not an attribute of hospital culture. The best example is how long has it been since the Institute of Medicine's *The Quality Chasm* was published and the how long has it taken hospitals to join the quality movement of evidence based medicine and patient focused care. What has been the motivator of joining? Money. Medicare incentive requirement of participating is worth two percent. Even with that, how many hospitals are meeting 100% of the individual measures or more importantly the composite measures. The result of this lack of change – striving for more cost effective care - is higher health care costs to Medicare and all of us. Why should ASCs be punished because hospitals are unwilling to provide effective and efficient quality care that reduces costs.

In conclusion, ASCs should be paid at a rate of 75% of your proposed fee schedule. The money to pay ASCs should come out of hospital outpatient department reimbursement as an incentive to hospitals to become more efficient and cost effective. The proposed 62% rate may force ASCs to cut back on services or to have the surgeries take place at the hospital which would increase costs for all. With a 75% rate, ASCs would be able to pay its bills and invest in future expansion that would provide additional procedures in the ASCs, thus reducing the cost to Medicare.

ASC LIST OF PROCEDURES

The ASC list of procedures show not be limited. The proposed list is far too restrictive. The decision as to the site of the surgery should be made by the surgeon with consultation with the patient. ASCs should be able to furnish and receive facility reimbursement for any and all procedure performed in HOPDs.

ANNUAL UPDATES OF PAYMENT RATES

Under current law, ASCs are provided no annual cost-of-living updates from 2004-2009, notwithstanding significant increases in the costs of delivering care. Commencing in 2010, CMS is proposing to pay ASCs an update equal to the consumer price index (CPI), while HOPDs would be paid an update based on the hospital market basket (HMB), which is typically higher. The HMB more appropriately reflects inflation in providing

surgical services than does the consumer price index. The new payment system should provide hospital market basket updates to both ASCs and HOPDs since both provide the same services and incur the same costs in delivering high quality surgical care.

PAYMENT RATES FOR OFFICE-TYPE PROCEDURES

Although CMS has added many ophthalmic services to the ASC list, the agency would pay for many office-type services, like laser procedures, at the Medicare Professional Fee Schedule practice expense amount, i.e., your current reimbursement rate, rather than at the 62% rate. As noted above, whatever percentage is ultimately adopted by CMS, it should be applied uniformly to all services, regardless of type.

ALIGNMENT OF PAYMENT SYSTEMS

Aligning the payment systems for ASCs and HOPDs will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. I believe the benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law.

Thank you for the opportunity to comment on these regulations. Eyecare Medical Group will continue to strive for the highest quality of patient care in a cost effective manner. Please help us in meeting our goals.

Respectfully submitted,

Clement Berry
Chief Executive Officer
Eyecare Medical Group
53 Sewall Street
Portland, Maine 04102

Submitter : Ms. Martina Manzone **Date:** 11/01/2006

Organization : DaVita

Category : End-Stage Renal Disease Facility

Issue Areas/Comments

GENERAL

GENERAL

It will be very beneficial for patients to be able to have dialysis access procedures performed in an ASC.

Submitter : Mrs. Debbie Wolfe **Date:** 11/01/2006

Organization : DaVita

Category : Nurse

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I support CMS practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

Please support patient choice! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

Submitter : Mrs. Debbie Wolfe **Date:** 11/01/2006

Organization : DaVita

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae.

The inclusion of CPT codes 35475, 35476, 36205 and 37206 to the list of Medicare approved ambulatory surgical center (ASC) procedures would provide Medicare the opportunity to reduce the cost of, and promote quality outcomes for, end-stage renal disease (ESRD) patients through more thoughtful reimbursement and regulation of vascular access procedures.

Submitter : Mr. Kevin Stuckey **Date:** 11/01/2006

Organization : Nueterra Healthcare

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mr. Bruce Goodwin **Date:** 11/01/2006

Organization : Nueterra Healthcare

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attached.

CMS-1506-P2-664-Attach-1.DOC

#664

NUETERRA
HEALTHCARE

November 1, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

I am writing regarding the proposed payment changes for Ambulatory Surgery Centers. I work for Nueterra Healthcare, a management company for ASCs. Through our affiliated centers, we serve thousands of Medicare recipients each year. We are very concerned that the changes, as currently proposed by CMS will have a detrimental affect on ASCs and the Medicare program.

Given the outdated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems. Although the HOPD payment system is imperfect, it represents the best proxy for the relative cost of procedures performed in the ASC.

In the comments to follow, we focus on three basic principles:

- maximizing the alignment of the ASC and HOPD payment systems eliminate distortions between the payment systems that could inappropriately influence site of service selection,
- ensuring beneficiary access to a wide range of surgical procedures that can be safely and efficiently performed in the ASC, and
- establishing fair and reasonable payment rates to allow beneficiaries and the Medicare program to save money on procedures that can be safely performed at a lower cost in the ASC than the HOPD.

Alignment of ASC and HOPD Payment Policies

Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost data used to evaluate outpatient surgical services for Medicare beneficiaries. The benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law. While we appreciate the many ways in which the agency

proposes to align the payment system, we are concerned that the linkage is incomplete and may lead to further distortions between the payment systems. Many policies applied to payments for hospital outpatient services were not extended to the ASC setting, and these inconsistencies undermine the appropriateness of the APC relative weights, create disparities in the relationship between the ASC and HOPD payment rates, and embed in the new payment system site of service incentives that will cost the taxpayer and the beneficiary more than necessary.

There are many components of the regulation where a more complete alignment of the ASC and HOPD payment systems is appropriate. Below is an overview of the major areas where further refinement of the proposed rule is warranted. These issues are discussed in greater detail under the relevant section heading in the text to follow.

- **Procedure list:** HOPDs are eligible for payment for any service not included on the inpatient only list. The CMS proposal would limit a physician's ability to determine appropriate site of service for a procedure excludes many surgical procedures appropriate for the ASC setting.

- **Treatment of unlisted codes:** Providers occasionally perform services or procedures for which CPT does not provide a specific code and therefore use an unlisted procedure code identify the service. HOPDs receive payment for such unlisted codes under OPPS; ASCs should also be eligible for payment of selected unlisted codes.

- **Different payment bundles:** Several of the policies for packaging ancillary and other procedure costs into the ASC payment bundle result in discrepancies between service costs represented in the APC relative weight. For example, when HOPDs perform services outside the surgical range that are not packaged, they receive additional payments for which ASCs should also be eligible.

- **Cap on office-based payments:** CMS proposes to cap payment for certain ASC procedures commonly performed in the office at the physician practice expense payment rate. No such limitation is applied to payments under the OPPS, presumably because the agency recognizes the cost of a procedure varies depending on the characteristics of the beneficiary and the resources available at the site of service. We likewise believe this cap is inappropriate for the ASC and should be omitted from the final regulation.

- **Different measures of inflation:** CMS updates the OPPS conversion factor for annual changes in inflation using the hospital market basket; however, the agency proposes to update ASC payments using the consumer price index for all urban consumers. The market basket is a better proxy for the inflationary pressures faced by ASCs, as it is the measure used by the agency to update payments to hospitals providing the same services.

- **Secondary rescaling of APC relative weights:** CMS applies a budget neutrality adjustment to the OPPS relative weight values after they are recalibrated with new cost data each year. The agency proposes a secondary recalibration of the relative weights before they are used by ASCs. This secondary recalibration will result in annual and potentially cumulative variation between ASC and HOPD payments without any evidence that the cost of providing services has further diverged between settings.

- **Non-application of HOPD policies to the ASC.** Over the years, CMS has implemented through statutory or administrative authority numerous policies to support services in the HOPD, including additional payment for high-cost outliers, transitional corridor and hold-harmless payments to rural and sole-community hospitals, and payments for new technologies. While not all of these policies are

appropriate for the ASC, surgery centers should be eligible to receive new technology pass-through payments.

- **Use of different billing systems:** The HOPD and ASC use the UB-92 and CMS-1500, respectively, to submit claims to the government for services. Use of different forms prevents ASCs from documenting all the services provided to a Medicare beneficiary, therefore undermining the documentation of case mix differences between sites of service. Most commercial payors require ASCs to submit claims using the UB-92, and the Medicare program should likewise align the payment system at the claim level.

Ensuring Beneficiaries' Access to Services

Ambulatory surgery centers are an important component of beneficiaries' access to surgical services. As innovations in science and technology have progressed, ASCs have demonstrated tremendous capacity to meet the growing need for outpatient surgical services. In some areas and specialties, ASCs are performing more than 50% of the volume for certain procedures. Sudden changes in payments for services can have a significant effect on Medicare beneficiaries' access to services predominantly performed in ASCs.

The implementation of the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs are typically focused on a narrow spectrum of services that require similar equipment and physician expertise, they have a limited ability to respond to changes in the payment system other than to adjust their volume of Medicare patients. On the one hand, for procedures such as ophthalmology, there is a limited market for these services in the non-Medicare population. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean relocating their practice to the HOPD. Such a decision would increase expenditures for the government and the beneficiary. On the other hand, the demand for services such as diagnostic colonoscopies is extremely high in the non-Medicare population. If ASCs determine that the payment rates for such services are too low, they may be able to decrease the proportion of Medicare patients they see without reducing their total patient volume. In that case, beneficiaries may experience significant delays accessing important preventive services or treatment. Neither outcome is optimal for the beneficiary of the Medicare program.

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neutrality under the agency's proposed rule. This, combined with the agency's narrow interpretation of budget neutrality, produce an unacceptably low conversion factor for ASC payments.

- Budget Neutrality: Adopt an expansive, realistic interpretation of budget neutrality. The new payment system and the expansion of the ASC list will result in migration of services from one site of service setting to another. CMS has the legal authority and the fiduciary responsibility to examine the consequences of the new ASC payment system on all sites of care – the physician office, ASCs, and HOPD.

- ASCs should comment on the possible negative effect on access to services, since the methodology proposed results in ASC payments equaling only 62% of HOPD.

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In conclusion, I am asking for a reconsideration of many of the elements of the proposed changes as outlined above. Truly aligning the ASC payment system with that of the HOPDs is the most logical, fair and best policy approach to benefit the Medicare program those served by the program. Should you have any questions regarding any of the issues in this letter, do not hesitate to contact me. My e-mail is kstuckey@nueterra.com, my phone number is 913-647-6452 and my mailing address is 11221 Roe Avenue, Suite 210, Leawood, KS 66211.

Sincerely,

Bruce Goodwin

Bruce Goodwin
Project Director

Submitter : Mr. Kevin Stuckey **Date:** 11/01/2006

Organization : Nueterra Healthcare

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attached.

CMS-1506-P2-665-Attach-1.DOC

#665

NUETERRA
HEALTHCARE

November 1, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

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Sincerely,

Kevin M. Stuckey

Kevin M. Stuckey
President & CEO

Submitter : Ms. Claire Peterson **Date:** 11/01/2006

Organization : Texan Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Coinsurance

ASC Coinsurance

We support retaining the Medicare beneficiary coinsurance for ASC services at 20 percent. For Medicare beneficiaries, lower coinsurance obligations will continue to be a significant advantage for choosing an ASC to meet their surgical needs. Beneficiaries will save significant dollars each year under the revised ASC payment system because ASC payments will in all cases be lower than the 20-40 percent HOPD coinsurance rates allowed under the OPPS.

ASC Conversion Factor

ASC Conversion Factor

62 % conversion factor is unacceptable and often does not cover the cost of the procedure. We understand that budget neutrality is mandated in the MMA of 2003; however, we believe that CMS made assumptions in order to reach budget neutrality with which we differ, most especially the migration of cases from and to the ASC. The ASC industry has worked together with our physicians and established a migration model that is being provided to CMS along with the data in an industry comment letter. We encourage CMS to accept this industry model.

ASC Office-Based Procedures

ASC Office-Based Procedures

We support CMS s proposal to extend the new ASC payment system to cover procedures that are commonly performed in physician offices. While physicians may safely perform many procedures on healthy Medicare beneficiaries in the office setting, sicker beneficiaries may require the additional infrastructure and safeguards of an ASC to maximize the probability of a good clinical outcome. In other words, for a given procedure, the appropriate site of service is dependent on the individual patient and his

ASC Payable Procedures

ASC Payable Procedures

We support CMS s decision to adopt MedPAC s recommendation from 2004 to replace the current inclusive list of ASC-covered procedures with an exclusionary list of procedures that would not be covered in ASCs based on two clinical criteria: (i) beneficiary safety; and (ii) the need for an overnight stay. However, the ASC list reform proposed by CMS is too limited. CMS should expand the ASC list of procedures to include any and all procedures that can be performed in an HOPD. CMS should exclude only those procedures that are on the inpatient only list and follow the state regulations for overnight stays.

ASC Phase In

ASC Phase In

Given the size of the payment cuts contemplated under the proposed rule for certain procedures and specialties; especially GI, pain and ophthalmology, one year does not provide adequate time to adjust to the changes. Thus, we believe the new system should be phased-in over several years.

ASC Ratesetting

ASC Ratesetting

We urge CMS to maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage index adjustments and the same inflation updates for ASCs and HOPDs.. These facilities exist in the same communities and often in partnership with the community hospital. Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. We believe that the benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law.

ASC Unlisted Procedures

ASC Unlisted Procedures

At a minimum, when all the specific codes in a given section of CPT are eligible for payment under the revised ASC payment system, the associated unlisted code also should be eligible for payment.

ASC Updates

ASC Updates

We are pleased that CMS is committing to annual updates of the new ASC payment system, and agree it makes sense to do that conjunction with the OPPS update cycle so as to help further advance transparency between the two systems. Regular, predictable and timely updates will promote beneficiary access to ASCs as changes in clinical practice and innovations in technology continue to expand the scope of services that can be safely performed on an outpatient basis.

Submitter : Mr. Erich Bauman **Date:** 11/01/2006

Organization : Davita Dialysis

Category : Nurse

Issue Areas/Comments

ASC Office-Based Procedures

ASC Office-Based Procedures

It would be foolish not to do outpatient vascular access creations. The amount of money spent on secondary infections from catheter access must be very high. This is the reason for the fistula first initiative to decrease the co-morbidities associated with catheters and provide citizens the best possible outcomes for dialysis patients. It is our responsibility to be fiscally responsible and also user friendly for the dialysis patients. It is far easier for the dialysis patient to be seen and have a procedure done safely then to overburden the hospital system that is struggling to meet the demands of the seriously ill. Advancement in technology has made the access creation safe in an outpatient setting.

Thanks you

Submitter : Ms. Meghan Dudek **Date:** 11/01/2006

Organization : Nueterra Healthcare

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attached.

CMS-1506-P2-668-Attach-1.DOC

#668

NUETERRA
HEALTHCARE

November 1, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

I am writing regarding the proposed payment changes for Ambulatory Surgery Centers. I work for Nueterra Healthcare, a management company for ASCs. Through our affiliated centers, we serve thousands of Medicare recipients each year. We are very concerned that the changes, as currently proposed by CMS will have a detrimental affect on ASCs and the Medicare program.

Given the outdated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems. Although the HOPD payment system is imperfect, it represents the best proxy for the relative cost of procedures performed in the ASC.

In the comments to follow, we focus on three basic principles:

- maximizing the alignment of the ASC and HOPD payment systems eliminate distortions between the payment systems that could inappropriately influence site of service selection,
- ensuring beneficiary access to a wide range of surgical procedures that can be safely and efficiently performed in the ASC, and
- establishing fair and reasonable payment rates to allow beneficiaries and the Medicare program to save money on procedures that can be safely performed at a lower cost in the ASC than the HOPD.

Alignment of ASC and HOPD Payment Policies

Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost data used to evaluate outpatient surgical services for Medicare beneficiaries. The benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law. While we appreciate the many ways in which the agency

proposes to align the payment system, we are concerned that the linkage is incomplete and may lead to further distortions between the payment systems. Many policies applied to payments for hospital outpatient services were not extended to the ASC setting, and these inconsistencies undermine the appropriateness of the APC relative weights, create disparities in the relationship between the ASC and HOPD payment rates, and embed in the new payment system site of service incentives that will cost the taxpayer and the beneficiary more than necessary.

There are many components of the regulation where a more complete alignment of the ASC and HOPD payment systems is appropriate. Below is an overview of the major areas where further refinement of the proposed rule is warranted. These issues are discussed in greater detail under the relevant section heading in the text to follow.

- **Procedure list:** HOPDs are eligible for payment for any service not included on the inpatient only list. The CMS proposal would limit a physician's ability to determine appropriate site of service for a procedure excludes many surgical procedures appropriate for the ASC setting.

- **Treatment of unlisted codes:** Providers occasionally perform services or procedures for which CPT does not provide a specific code and therefore use an unlisted procedure code identify the service. HOPDs receive payment for such unlisted codes under OPPS; ASCs should also be eligible for payment of selected unlisted codes.

- **Different payment bundles:** Several of the policies for packaging ancillary and other procedure costs into the ASC payment bundle result in discrepancies between service costs represented in the APC relative weight. For example, when HOPDs perform services outside the surgical range that are not packaged, they receive additional payments for which ASCs should also be eligible.

- **Cap on office-based payments:** CMS proposes to cap payment for certain ASC procedures commonly performed in the office at the physician practice expense payment rate. No such limitation is applied to payments under the OPPS, presumably because the agency recognizes the cost of a procedure varies depending on the characteristics of the beneficiary and the resources available at the site of service. We likewise believe this cap is inappropriate for the ASC and should be omitted from the final regulation.

- **Different measures of inflation:** CMS updates the OPPS conversion factor for annual changes in inflation using the hospital market basket; however, the agency proposes to update ASC payments using the consumer price index for all urban consumers. The market basket is a better proxy for the inflationary pressures faced by ASCs, as it is the measure used by the agency to update payments to hospitals providing the same services.

- **Secondary rescaling of APC relative weights:** CMS applies a budget neutrality adjustment to the OPPS relative weight values after they are recalibrated with new cost data each year. The agency proposes a secondary recalibration of the relative weights before they are used by ASCs. This secondary recalibration will result in annual and potentially cumulative variation between ASC and HOPD payments without any evidence that the cost of providing services has further diverged between settings.

- **Non-application of HOPD policies to the ASC.** Over the years, CMS has implemented through statutory or administrative authority numerous policies to support services in the HOPD, including additional payment for high-cost outliers, transitional corridor and hold-harmless payments to rural and sole-community hospitals, and payments for new technologies. While not all of these policies are

appropriate for the ASC, surgery centers should be eligible to receive new technology pass-through payments.

- **Use of different billing systems:** The HOPD and ASC use the UB-92 and CMS-1500, respectively, to submit claims to the government for services. Use of different forms prevents ASCs from documenting all the services provided to a Medicare beneficiary, therefore undermining the documentation of case mix differences between sites of service. Most commercial payors require ASCs to submit claims using the UB-92, and the Medicare program should likewise align the payment system at the claim level.

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Ambulatory surgery centers are an important component of beneficiaries' access to surgical services. As innovations in science and technology have progressed, ASCs have demonstrated tremendous capacity to meet the growing need for outpatient surgical services. In some areas and specialties, ASCs are performing more than 50% of the volume for certain procedures. Sudden changes in payments for services can have a significant effect on Medicare beneficiaries' access to services predominantly performed in ASCs.

The implementation of the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs are typically focused on a narrow spectrum of services that require similar equipment and physician expertise, they have a limited ability to respond to changes in the payment system other than to adjust their volume of Medicare patients. On the one hand, for procedures such as ophthalmology, there is a limited market for these services in the non-Medicare population. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean relocating their practice to the HOPD. Such a decision would increase expenditures for the government and the beneficiary. On the other hand, the demand for services such as diagnostic colonoscopies is extremely high in the non-Medicare population. If ASCs determine that the payment rates for such services are too low, they may be able to decrease the proportion of Medicare patients they see without reducing their total patient volume. In that case, beneficiaries may experience significant delays accessing important preventive services or treatment. Neither outcome is optimal for the beneficiary of the Medicare program.

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Medicare payment rates for ASC services have remained stagnant for nearly a decade. Over time, the industry has identified which services it can continue to offer to Medicare beneficiaries through reductions in cost and improvements in efficiency. In the Medicare Payment Advisory Commission's first review of ASC payments in 2003, ASCs were paid more than the HOPD for eight of the top ten procedures most frequently performed in the ASC. One suggestion by the commission was that services migrated to the ASC because the payment rate was higher than the HOPD. However, a multi-year payment freeze on ASC services has turned the tables and now the HOPD rate in 2007 will be higher (or the same) for eight of the same ten ASC procedures. The continued growth of ASCs during the payment freeze is a strong testament to their ability to improve their efficiency and the preference of physicians and beneficiaries for an alternative to the hospital outpatient surgical environment.

The impact of HOPD payments eclipsing the ASC rates has had the perverse effect of increasing the "cost" of the budget neutrality requirement imposed by the Medicare Modernization Act on the future conversion factor for ASC payments. The Lewin Group estimates that the inflation updates applied to the HOPD rates since passage of the MMA account for 40 percent of the discount required to achieve budget

neutrality under the agency's proposed rule. This, combined with the agency's narrow interpretation of budget neutrality, produce an unacceptably low conversion factor for ASC payments.

- Budget Neutrality: Adopt an expansive, realistic interpretation of budget neutrality. The new payment system and the expansion of the ASC list will result in migration of services from one site of service setting to another. CMS has the legal authority and the fiduciary responsibility to examine the consequences of the new ASC payment system on all sites of care – the physician office, ASCs, and HOPD.

- ASCs should comment on the possible negative effect on access to services, since the methodology proposed results in ASC payments equaling only 62% of HOPD.

- By setting rates this low, CMS would force doctors to move cases to the more expensive hospital setting, increasing the amount of money paid by Medicare beneficiaries and the government. Rather than paying ASCs a set percentage of HOPD rates, the proposed rule establishes a complicated formula to link ASC payment to HOPD payment but does not link payment in a uniform manner. This will impede Medicare beneficiaries' ability to understand their real costs in alternative settings. In the words of President Bush, Medicare beneficiaries need to be able to make "apples to apples" comparisons in order to increase transparency in the health care sector.

- CMS failed to include on the procedure list many higher complexity services that have for years been safely and effectively performed in ASCs throughout the country. By not creating a truly exclusionary list, CMS is losing an opportunity to increase patient choice and rely on the clinical judgment of the surgeon.

In conclusion, I am asking for a reconsideration of many of the elements of the proposed changes as outlined above. Truly aligning the ASC payment system with that of the HOPDs is the most logical, fair and best policy approach to benefit the Medicare program those served by the program. Should you have any questions regarding any of the issues in this letter, do not hesitate to contact me. My e-mail is kstuckey@nueterra.com, my phone number is 913-647-6452 and my mailing address is 11221 Roe Avenue, Suite 210, Leawood, KS 66211.

Sincerely,

Meghan Dudek

Meghan Dudek
Interior Designer

Submitter : Ms. Becky Andrews **Date:** 11/01/2006

Organization : Nueterra Healthcare

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attached.

CMS-1506-P2-669-Attach-1.DOC

#669

NUETERRA
HEALTHCARE

November 1, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P Room 445-G
Hubert H. Humphrey Building
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Sincerely,

Becky Andrews

Becky Andrews
Property Management Director

Submitter : Mr. Mike Rothwell **Date:** 11/01/2006

Organization : Nueterra Healthcare

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attached.

CMS-1506-P2-670-Attach-1.DOC

#670

NUETERRA
HEALTHCARE

November 1, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P Room 445-G
Hubert H. Humphrey Building
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Sincerely,

Mike Rothwell

Mike Rothwell
Controller

Submitter : Mrs. Danielle Peehler **Date:** 11/01/2006

Organization : Lawrenceville Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Coinsurance

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Submitter : Mr. Christopher Smith **Date:** 11/01/2006

Organization : Nueterra Healthcare

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attached.

CMS-1506-P2-672-Attach-1.DOC

#672

NUETERRA
HEALTHCARE

November 1, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

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proposes to align the payment system, we are concerned that the linkage is incomplete and may lead to further distortions between the payment systems. Many policies applied to payments for hospital outpatient services were not extended to the ASC setting, and these inconsistencies undermine the appropriateness of the APC relative weights, create disparities in the relationship between the ASC and HOPD payment rates, and embed in the new payment system site of service incentives that will cost the taxpayer and the beneficiary more than necessary.

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The implementation of the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs are typically focused on a narrow spectrum of services that require similar equipment and physician expertise, they have a limited ability to respond to changes in the payment system other than to adjust their volume of Medicare patients. On the one hand, for procedures such as ophthalmology, there is a limited market for these services in the non-Medicare population. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean relocating their practice to the HOPD. Such a decision would increase expenditures for the government and the beneficiary. On the other hand, the demand for services such as diagnostic colonoscopies is extremely high in the non-Medicare population. If ASCs determine that the payment rates for such services are too low, they may be able to decrease the proportion of Medicare patients they see without reducing their total patient volume. In that case, beneficiaries may experience significant delays accessing important preventive services or treatment. Neither outcome is optimal for the beneficiary of the Medicare program.

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Sincerely,

Christopher Smith

Christopher Smith
VP, Business Development

Submitter : Ms. Cindy Webb **Date:** 11/01/2006

Organization : Nueterra Healthcare

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

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See Attached.

CMS-1506-P2-673-Attach-1.DOC

NUETERRA
HEALTHCARE

November 1, 2006

Leslie V. Norwalk, Esq., Acting Administrator
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Attention: CMS-1506-P Room 445-G
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Sincerely,

Cindy Webb

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Accountant

Submitter : Dr. Robert Wyatt **Date:** 11/01/2006

Organization : Baylor Surgicare North Garland

Category : Physician

Issue Areas/Comments

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GENERAL

GENERAL

I am a member of the Board of Mangers of a local ASC in my area that I strongly believe has greatly improved both the quality of healthcare in the area as well as access to care for Medicare beneficiaries.

Submitter : Ms. Stacy Blauser **Date:** 11/01/2006

Organization : Nueterra Healthcare

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attached.

CMS-1506-P2-675-Attach-1.DOC

#675

NUETERRA
HEALTHCARE

November 1, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P Room 445-G
Hubert H. Humphrey Building
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The implementation of the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs are typically focused on a narrow spectrum of services that require similar equipment and physician expertise, they have a limited ability to respond to changes in the payment system other than to adjust their volume of Medicare patients. On the one hand, for procedures such as ophthalmology, there is a limited market for these services in the non-Medicare population. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean relocating their practice to the HOPD. Such a decision would increase expenditures for the government and the beneficiary. On the other hand, the demand for services such as diagnostic colonoscopies is extremely high in the non-Medicare population. If ASCs determine that the payment rates for such services are too low, they may be able to decrease the proportion of Medicare patients they see without reducing their total patient volume. In that case, beneficiaries may experience significant delays accessing important preventive services or treatment. Neither outcome is optimal for the beneficiary of the Medicare program.

Establishing Reasonable Reimbursement Rates

Medicare payment rates for ASC services have remained stagnant for nearly a decade. Over time, the industry has identified which services it can continue to offer to Medicare beneficiaries through reductions in cost and improvements in efficiency. In the Medicare Payment Advisory Commission's first review of ASC payments in 2003, ASCs were paid more than the HOPD for eight of the top ten procedures most frequently performed in the ASC. One suggestion by the commission was that services migrated to the ASC because the payment rate was higher than the HOPD. However, a multi-year payment freeze on ASC services has turned the tables and now the HOPD rate in 2007 will be higher (or the same) for eight of the same ten ASC procedures. The continued growth of ASCs during the payment freeze is a strong testament to their ability to improve their efficiency and the preference of physicians and beneficiaries for an alternative to the hospital outpatient surgical environment.

The impact of HOPD payments eclipsing the ASC rates has had the perverse effect of increasing the "cost" of the budget neutrality requirement imposed by the Medicare Modernization Act on the future conversion factor for ASC payments. The Lewin Group estimates that the inflation updates applied to the HOPD rates since passage of the MMA account for 40 percent of the discount required to achieve budget

neutrality under the agency's proposed rule. This, combined with the agency's narrow interpretation of budget neutrality, produce an unacceptably low conversion factor for ASC payments.

- Budget Neutrality: Adopt an expansive, realistic interpretation of budget neutrality. The new payment system and the expansion of the ASC list will result in migration of services from one site of service setting to another. CMS has the legal authority and the fiduciary responsibility to examine the consequences of the new ASC payment system on all sites of care – the physician office, ASCs, and HOPD.

- ASCs should comment on the possible negative effect on access to services, since the methodology proposed results in ASC payments equaling only 62% of HOPD.

- By setting rates this low, CMS would force doctors to move cases to the more expensive hospital setting, increasing the amount of money paid by Medicare beneficiaries and the government. Rather than paying ASCs a set percentage of HOPD rates, the proposed rule establishes a complicated formula to link ASC payment to HOPD payment but does not link payment in a uniform manner. This will impede Medicare beneficiaries' ability to understand their real costs in alternative settings. In the words of President Bush, Medicare beneficiaries need to be able to make "apples to apples" comparisons in order to increase transparency in the health care sector.

- CMS failed to include on the procedure list many higher complexity services that have for years been safely and effectively performed in ASCs throughout the country. By not creating a truly exclusionary list, CMS is losing an opportunity to increase patient choice and rely on the clinical judgment of the surgeon.

In conclusion, I am asking for a reconsideration of many of the elements of the proposed changes as outlined above. Truly aligning the ASC payment system with that of the HOPDs is the most logical, fair and best policy approach to benefit the Medicare program those served by the program. Should you have any questions regarding any of the issues in this letter, do not hesitate to contact me. My e-mail is kstuckey@nueterra.com, my phone number is 913-647-6452 and my mailing address is 11221 Roe Avenue, Suite 210, Leawood, KS 66211.

Sincerely,

Stacy Blauser

Stacy Blauser
Accountant

Submitter : Ms. Debbie Hunt **Date:** 11/01/2006

Organization : Nueterra Healthcare

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attached.

CMS-1506-P2-676-Attach-1.DOC

#676

NUETERRA
HEALTHCARE

November 1, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

I am writing regarding the proposed payment changes for Ambulatory Surgery Centers. I work for Nueterra Healthcare, a management company for ASCs. Through our affiliated centers, we serve thousands of Medicare recipients each year. We are very concerned that the changes, as currently proposed by CMS will have a detrimental affect on ASCs and the Medicare program.

Given the outdated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems. Although the HOPD payment system is imperfect, it represents the best proxy for the relative cost of procedures performed in the ASC.

In the comments to follow, we focus on three basic principles:

- maximizing the alignment of the ASC and HOPD payment systems eliminate distortions between the payment systems that could inappropriately influence site of service selection,
- ensuring beneficiary access to a wide range of surgical procedures that can be safely and efficiently performed in the ASC, and
- establishing fair and reasonable payment rates to allow beneficiaries and the Medicare program to save money on procedures that can be safely performed at a lower cost in the ASC than the HOPD.

Alignment of ASC and HOPD Payment Policies

Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost data used to evaluate outpatient surgical services for Medicare beneficiaries. The benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law. While we appreciate the many ways in which the agency

proposes to align the payment system, we are concerned that the linkage is incomplete and may lead to further distortions between the payment systems. Many policies applied to payments for hospital outpatient services were not extended to the ASC setting, and these inconsistencies undermine the appropriateness of the APC relative weights, create disparities in the relationship between the ASC and HOPD payment rates, and embed in the new payment system site of service incentives that will cost the taxpayer and the beneficiary more than necessary.

There are many components of the regulation where a more complete alignment of the ASC and HOPD payment systems is appropriate. Below is an overview of the major areas where further refinement of the proposed rule is warranted. These issues are discussed in greater detail under the relevant section heading in the text to follow.

- **Procedure list:** HOPDs are eligible for payment for any service not included on the inpatient only list. The CMS proposal would limit a physician's ability to determine appropriate site of service for a procedure excludes many surgical procedures appropriate for the ASC setting.

- **Treatment of unlisted codes:** Providers occasionally perform services or procedures for which CPT does not provide a specific code and therefore use an unlisted procedure code identify the service. HOPDs receive payment for such unlisted codes under OPPS; ASCs should also be eligible for payment of selected unlisted codes.

- **Different payment bundles:** Several of the policies for packaging ancillary and other procedure costs into the ASC payment bundle result in discrepancies between service costs represented in the APC relative weight. For example, when HOPDs perform services outside the surgical range that are not packaged, they receive additional payments for which ASCs should also be eligible.

- **Cap on office-based payments:** CMS proposes to cap payment for certain ASC procedures commonly performed in the office at the physician practice expense payment rate. No such limitation is applied to payments under the OPPS, presumably because the agency recognizes the cost of a procedure varies depending on the characteristics of the beneficiary and the resources available at the site of service. We likewise believe this cap is inappropriate for the ASC and should be omitted from the final regulation.

- **Different measures of inflation:** CMS updates the OPPS conversion factor for annual changes in inflation using the hospital market basket; however, the agency proposes to update ASC payments using the consumer price index for all urban consumers. The market basket is a better proxy for the inflationary pressures faced by ASCs, as it is the measure used by the agency to update payments to hospitals providing the same services.

- **Secondary rescaling of APC relative weights:** CMS applies a budget neutrality adjustment to the OPPS relative weight values after they are recalibrated with new cost data each year. The agency proposes a secondary recalibration of the relative weights before they are used by ASCs. This secondary recalibration will result in annual and potentially cumulative variation between ASC and HOPD payments without any evidence that the cost of providing services has further diverged between settings.

- **Non-application of HOPD policies to the ASC.** Over the years, CMS has implemented through statutory or administrative authority numerous policies to support services in the HOPD, including additional payment for high-cost outliers, transitional corridor and hold-harmless payments to rural and sole-community hospitals, and payments for new technologies. While not all of these policies are

appropriate for the ASC, surgery centers should be eligible to receive new technology pass-through payments.

- **Use of different billing systems:** The HOPD and ASC use the UB-92 and CMS-1500, respectively, to submit claims to the government for services. Use of different forms prevents ASCs from documenting all the services provided to a Medicare beneficiary, therefore undermining the documentation of case mix differences between sites of service. Most commercial payors require ASCs to submit claims using the UB-92, and the Medicare program should likewise align the payment system at the claim level.

Ensuring Beneficiaries' Access to Services

Ambulatory surgery centers are an important component of beneficiaries' access to surgical services. As innovations in science and technology have progressed, ASCs have demonstrated tremendous capacity to meet the growing need for outpatient surgical services. In some areas and specialties, ASCs are performing more than 50% of the volume for certain procedures. Sudden changes in payments for services can have a significant effect on Medicare beneficiaries' access to services predominantly performed in ASCs.

The implementation of the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs are typically focused on a narrow spectrum of services that require similar equipment and physician expertise, they have a limited ability to respond to changes in the payment system other than to adjust their volume of Medicare patients. On the one hand, for procedures such as ophthalmology, there is a limited market for these services in the non-Medicare population. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean relocating their practice to the HOPD. Such a decision would increase expenditures for the government and the beneficiary. On the other hand, the demand for services such as diagnostic colonoscopies is extremely high in the non-Medicare population. If ASCs determine that the payment rates for such services are too low, they may be able to decrease the proportion of Medicare patients they see without reducing their total patient volume. In that case, beneficiaries may experience significant delays accessing important preventive services or treatment. Neither outcome is optimal for the beneficiary of the Medicare program.

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neutrality under the agency's proposed rule. This, combined with the agency's narrow interpretation of budget neutrality, produce an unacceptably low conversion factor for ASC payments.

- Budget Neutrality: Adopt an expansive, realistic interpretation of budget neutrality. The new payment system and the expansion of the ASC list will result in migration of services from one site of service setting to another. CMS has the legal authority and the fiduciary responsibility to examine the consequences of the new ASC payment system on all sites of care – the physician office, ASCs, and HOPD.

- ASCs should comment on the possible negative effect on access to services, since the methodology proposed results in ASC payments equaling only 62% of HOPD.

- By setting rates this low, CMS would force doctors to move cases to the more expensive hospital setting, increasing the amount of money paid by Medicare beneficiaries and the government. Rather than paying ASCs a set percentage of HOPD rates, the proposed rule establishes a complicated formula to link ASC payment to HOPD payment but does not link payment in a uniform manner. This will impede Medicare beneficiaries' ability to understand their real costs in alternative settings. In the words of President Bush, Medicare beneficiaries need to be able to make "apples to apples" comparisons in order to increase transparency in the health care sector.

- CMS failed to include on the procedure list many higher complexity services that have for years been safely and effectively performed in ASCs throughout the country. By not creating a truly exclusionary list, CMS is losing an opportunity to increase patient choice and rely on the clinical judgment of the surgeon.

In conclusion, I am asking for a reconsideration of many of the elements of the proposed changes as outlined above. Truly aligning the ASC payment system with that of the HOPDs is the most logical, fair and best policy approach to benefit the Medicare program those served by the program. Should you have any questions regarding any of the issues in this letter, do not hesitate to contact me. My e-mail is kstuckey@nueterra.com, my phone number is 913-647-6452 and my mailing address is 11221 Roe Avenue, Suite 210, Leawood, KS 66211.

Sincerely,

Debbie Hunt

Debbie Hunt
Development Coordinator

Submitter : Dr. Ali Assefi **Date:** 11/01/2006

Organization : Nephrology Associates of Northern Virginia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

In my opinion it is safe to do vascular access work in ASC setting .
Payment for angioplasty should be included in ASC payment schedelle.

Submitter : Joy Kurosaka **Date:** 11/01/2006

Organization : Court Street Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Coinsurance

ASC Coinsurance

We support retaining the Medicare benificiary coinsurance for ASC services at 20 percent. For Medicare beneficiaries, lower coinsurance obligations will continue to be a significant advantage for choosing an ASC to meet their surgical needs. Beneficiaries will save significant dollars each year under the revised ASC payment system because ASC payments will in all cases be lower than the 20-40 percent coinsurance rates allowed under the OPPS.

ASC Conversion Factor

ASC Conversion Factor

62% conversion factor is unacceptable and often does not cover the cost of the procedure. We understand that udget neutrality is mandated in the MMA of 2003; however, we beleive that CMS mad assumptions in order to reach budget neutrality with which we differ, most especially the migration of cases from and to the ASC. The ASC has worked together with our physicians and estabalished a mogration model that is being provided to CMS along with the data in an industry comment letter. We encourage CMS to accept this industry model.

ASC Office-Based Procedures

ASC Office-Based Procedures

The apporpriate site for services should be dependent on the individual patient and his specific condition and not restricted by a location to ensure safe care.

ASC Packaging

ASC Packaging

We urge CMS to maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage index adjustments and the same inflation updates for ASCs and HOPDs.

ASC Payable Procedures

ASC Payable Procedures

We support CMS's decision to adopt MedPAC's recommendation from woo4 to replace the current "inclusive" list of ASC-covered procedures with an "exclusionary" list of procedures that would not be covered in the ASC's based on two clinical criteria: beneficiary safety and the need to stay overnight. However, the ASC list reform proposed by CMS is too limited. CMS should expand the ASC list of procedures to include any and all procedures that can be performed in an HOPD. CMS should exclude only those procedures that are on the inpatient only list and follow the state regulations for overnight stays.

ASC Phase In

ASC Phase In

Given the size of the payment cuts contemplated under the proposed rule for certain procedures and specialties: especially GI, pain and ophthalmology, one year does not provide adequate time to adjust to the changes. We beleive the new system should be phased-in over several years.

ASC Unlisted Procedures

ASC Unlisted Procedures

At a minimum, when all the specific cides in a given section of CPT are eligible for payment under the revised ASC payment system, the associated unlisted codes should also be eligible for payment.

ASC Updates

ASC Updates

We are pleased that CMS is committing to annual updates of the new ASC payment system and agree it makes sense to do that in conjunction with the OPPS update cycle so as to help further advance transparency between the two systems. Regular, predictable and timely updates will promote beneficiary access to ASCs as changes in clinical practice and innovation in technology continue to expand the scope of services that can be safely performed on an outpatient basis.

Submitter : Mrs. Terri Westerberg **Date:** 11/01/2006

Organization : Idaho Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Coinsurance

ASC Coinsurance

We support retaining the Medicare beneficiary coinsurance for ASC services at 20 percent. For Medicare beneficiaries, lower coinsurance obligations will continue to be a significant advantage for choosing an ASC to meet their surgical needs. Beneficiaries will save significant dollars each year under the revised ASC payment system because ASC payments will in all cases be lower than the 20-40 percent HOPD coinsurance rates allowed under the OPPS.

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ASC Office-Based Procedures

ASC Office-Based Procedures

We support CMS's proposal to extend the new ASC payment system to cover procedures that are commonly performed in physician offices. While physicians may safely perform many procedures on healthy Medicare beneficiaries in the office setting, sicker beneficiaries may require the additional infrastructure and safeguards of an ASC to maximize the probability of a good clinical outcome. In other words, for a given procedure, the appropriate site of service is dependent on the individual patient and his specific condition.

ASC Payable Procedures

ASC Payable Procedures

We support CMS's decision to adopt MedPAC's recommendation from 2004 to replace the current "inclusive" list of ASC-covered procedures with an "exclusionary" list of procedures that would not be covered in ASCs based on two clinical criteria:)i) beneficiary safety; and (ii) the need for an overnight stay. However, the ASC list reform proposed by CMS is too limited. CMS should expand the ASC list of procedures to include any and all procedures that can be performed in an HOPD. CMS should exclude only those procedures that are on the inpatient only list and follow the state regulations for overnight stays.

ASC Phase In

ASC Phase In

Given the size of the payment cuts contemplated under the proposed rule for certain procedures and specialties; especially GI, pain and opthalmology, one year does not provide adequate time to adjust to the changes. Thus, we believe the new system should be phased-in over several years.

ASC Ratesetting

ASC Ratesetting

We urge CMS to maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage index adjustments and the same inflation updates for ASCs and HOPDs. These facilities exist in the same communities and often in partnership with the community hospital. Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. We believe that the benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law.

ASC Unlisted Procedures

ASC Unlisted Procedures

At a minimum, when all the specific codes in a given section of CPT are eligible for payment under the revised ASC payment system, the associated unlisted code also should be eligible for payment.

ASC Updates

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We are pleased that CMS is committing to annual updates of the new ASC payment system, and agree it makes sense to do that conjunction with the OPPS update cycle so as to help further advance transparency between the two systems. Regular, predictable and timely updates will promote beneficiary access to ASCs as changes in clinical practice and innovations in technology continue to expand the scope of services that can be safely performed on an outpatient basis.

Submitter : Mr. Craig Hethcox **Date:** 11/01/2006

Organization : NovaMed, Inc.

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1506-P2-680-Attach-1.DOC

CMS-1506-P2-680-Attach-2.DOC

#680

November 1, 2006

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P-Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

I am in opposition to the proposed new rate-basing system for ambulatory surgery centers. The proposal limits the cases that Medicare will reimburse in an ASC and proposes to pay ASC's only 62% of what hospital inpatients departments receive.

Surgery centers need to be treated the same as hospitals and not as second-class providers. Our health system grants equal status to all who seek services and I trust you will agree with an equal status concept in our payment system.

Respectfully,
Craig Hethcox
Atlanta, GA

Submitter : Ms. Kathleen Sheehan **Date:** 11/01/2006

Organization : Davita Hill Country Dialysis

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I support patients getting access to surgery making dialysis possible and safe for them.

Submitter : **Ms. Jan Braun** **Date: 11/01/2006**

Organization : **DaVita**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae.

CMS-1506-P2-682-Attach-1.DOC

#682

November 1, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P2
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Sirs:

I request consideration for the following comments for CMS 1506-P2; The Hospital Outpatient Prospective Payment Systems and CY 2007 payment Rates; FY 2008 ASC Payment.

General Comments

Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae

The inclusion of CPT codes 35475, 35476, 36205 and 37206 to the list of Medicare approved ambulatory surgical center (ASC) procedures **would** provide Medicare the opportunity to reduce the cost of, and promote quality outcomes for, end-stage renal disease (ESRD) patients through more thoughtful reimbursement and regulation of vascular access procedures.

ASC Payable Procedures (Exclusion Criteria)

We support CMS' practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list

Please support patient choice! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular

access repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS' Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting. **This is extremely important to me as I interact each day with our patients**

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

Thank you.

Sincerely,

Jan Braun

4422 General Meyer Avenue

New Orleans, LA 70131

Submitter :

Date: 11/01/2006

Organization :

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See Attachment

CMS-1506-P2-683-Attach-1.DOC

#683

Bradenton Eye Clinic

4812 26th Street West
Bradenton, FL 34207
941-727-3937

October 31, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1506-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Sir or Madam:

I am writing to comment on the proposed 2007 and 2008 changes to the ambulatory surgical center payment system. I would like to make sure that all Medicare beneficiaries have access to ambulatory surgical centers (ASCs). I am hoping that CMS will broadly interpret the budget neutrality provision enacted by Congress. I feel that offering to reimburse ASCs 62% of the hospital outpatient department (HOPD) fee schedule is simply not adequate for us to provide quality, safe care.

I also feel the ASC list reform proposed by CMS is too limited. I hope that CMS will expand the ASC list of procedures to include any and all procedures that can be performed in a HOPD. CMS should exclude only those procedures that are on the inpatient only list.

ASC reimbursements should be updated based upon the hospital market basket because this more appropriately reflects inflation in providing surgical services than does the consumer price index. I feel the same relative weights should be used in ASCs and hospital outpatient departments.

Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. I believe that the benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law.

For these reasons, I respectfully request CMS revise the proposed 2007 and 2008 ambulatory surgical center payment system and increase the reimbursement percentage to at least 75%.

Sincerely,

Liaquat Allarakhia, M.D.

Submitter : Dr. Nikola Zivaljevic **Date:** 11/01/2006

Organization : Western PA Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Ratesetting

ASC Ratesetting

To whom it may concern:

Linking the ASC reimbursements to HOPD reimbursements is long overdue. Yet valuing the same services provided at an ASC at 62% compared to the HOPD reimbursements is simply not adequate. If anything, physicians in an ASC provide better quality, state of the art care and use significantly less ancillary services than physicians providing the same services in an HOPD. For instance, physicians in a HOPD are far more likely to transfer patients to the adjacent hospital than physicians in an ASC, even if the patient population and procedures are comparable. Thus just comparing the procedures alone does not tell the whole story about the cost of a rendering care in this two settings.

The ASC procedure list also needs simplified by only excluding procedures on an inpatient only list. In regards to inflation adjustments, it is probably no news to you that the inflation in health care is significantly above the general inflation rate. This should be taken into consideration, too, than revising the reimbursement systems.

In order to really make accurate comparisons between ASC and HOPDs, the rules for both should be identical. That is the only way to compare apples to apples and extract comparable cost data.

Best regards,

Dr. Nikola Zivaljevic MBA, MHMS
Administrative Director
Western PA Surgery Center

CY 2008 ASC Impact

CY 2008 ASC Impact

To whom it may concern:

Linking the ASC reimbursements to HOPD reimbursements is long overdue. Yet valuing the same services provided at an ASC at 62% compared to the HOPD reimbursements is simply not adequate. If anything, physicians in an ASC provide better quality, state of the art care and use significantly less ancillary services than physicians providing the same services in an HOPD. For instance, physicians in a HOPD are far more likely to transfer patients to the adjacent hospital than physicians in an ASC, even if the patient population and procedures are comparable. Thus just comparing the procedures alone does not tell the whole story about the cost of a rendering care in this two settings.

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Best regards,

Dr. Nikola Zivaljevic MBA, MHMS
Administrative Director
Western PA Surgery Center

CMS-1506-P2-684-Attach-1.DOC

#1684

To whom it may concern:

Linking the ASC reimbursements to HOPD reimbursements is long overdue. Yet valuing the same services provided at an ASC at 62% compared to the HOPD reimbursements is simply not adequate. If anything, physicians in an ASC provide better quality, state of the art care and use significantly less ancillary services than physicians providing the same services in an HOPD. For instance, physicians in a HOPD are far more likely to transfer patients to the adjacent hospital than physicians in an ASC, even if the patient population and procedures are comparable. Thus just comparing the procedures alone does not tell the whole story about the cost of a rendering care in this two settings.

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In order to really make accurate comparisons between ASC and HOPDs, the rules for both should be identical. That is the only way to compare apples to apples and extract comparable cost data.

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Dr. Nikola Zivaljevic MBA, MHMS
Administrative Director
Western PA Surgery Center

Submitter : **Date: 11/01/2006**

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See Attachment

CMS-1506-P2-685-Attach-1.DOC

#685-

Palm Coast Eye Center, P.A.

5601A 21st Avenue West
Bradenton, FL 34209
941-794-2020

October 31, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1506-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Sir or Madam:

I am writing to comment on the proposed 2007 and 2008 changes to the ambulatory surgical center payment system. I would like to make sure that all Medicare beneficiaries have access to ambulatory surgical centers (ASCs). I am hoping that CMS will broadly interpret the budget neutrality provision enacted by Congress. I feel that offering to reimburse ASCs 62% of the hospital outpatient department (HOPD) fee schedule is simply not adequate for us to provide quality, safe care.

I also feel the ASC list reform proposed by CMS is too limited. I hope that CMS will expand the ASC list of procedures to include any and all procedures that can be performed in a HOPD. CMS should exclude only those procedures that are on the inpatient only list.

ASC reimbursements should be updated based upon the hospital market basket because this more appropriately reflects inflation in providing surgical services than does the consumer price index. I feel the same relative weights should be used in ASCs and hospital outpatient departments.

Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. I believe that the benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law.

For these reasons, I respectfully request CMS revise the proposed 2007 and 2008 ambulatory surgical center payment system and increase the reimbursement percentage to at least 75%.

Sincerely,

Dana J. Weinkle, M.D.

Submitter : **Mrs. Deborah Sczepczenski** **Date: 11/01/2006**

Organization : **Montclair Dialysis Center**

Category : **End-Stage Renal Disease Facility**

Issue Areas/Comments

GENERAL

GENERAL

SAMPLE COMMENTS

Click here for a sample letter ready for you to mail to CMS.
Or, cut and paste the sample comments below and use them
when completing the CMS online comment form.

Sample for CMS Online Comment Section titled
"ASC Payable Procedures"

I support CMS practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

Please support patient choice! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

Submitter : **Date: 11/01/2006**

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See Attachment

CMS-1506-P2-687-Attach-1.DOC

#687

Jose F. Estibarribia, M.D.

4810 26th Street West
Bradenton, FL 34207
941-753-7073

October 31, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1506-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Sir or Madam:

I am writing to comment on the proposed 2007 and 2008 changes to the ambulatory surgical center payment system. I would like to make sure that all Medicare beneficiaries have access to ambulatory surgical centers (ASCs). I am hoping that CMS will broadly interpret the budget neutrality provision enacted by Congress. I feel that offering to reimburse ASCs 62% of the hospital outpatient department (HOPD) fee schedule is simply not adequate for us to provide quality, safe care.

I also feel the ASC list reform proposed by CMS is too limited. I hope that CMS will expand the ASC list of procedures to include any and all procedures that can be performed in a HOPD. CMS should exclude only those procedures that are on the inpatient only list.

ASC reimbursements should be updated based upon the hospital market basket because this more appropriately reflects inflation in providing surgical services than does the consumer price index. I feel the same relative weights should be used in ASCs and hospital outpatient departments.

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Sincerely,

Jose F. Estigarribia, M.D.

Submitter : **Date: 11/01/2006**

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Date: 11/01/2006**

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See Attachment

CMS-1506-P2-689-Attach-1.DOC

FF 1687

Ear, Nose & Throat Associates of Manatee, P.A.

701 Manatee Ave. W.
Bradenton, FL 34205
941-748-2455

October 31, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1506-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Sir or Madam:

I am writing to comment on the proposed 2007 and 2008 changes to the ambulatory surgical center payment system. I would like to make sure that all Medicare beneficiaries have access to ambulatory surgical centers (ASCs). I am hoping that CMS will broadly interpret the budget neutrality provision enacted by Congress. I feel that offering to reimburse ASCs 62% of the hospital outpatient department (HOPD) fee schedule is simply not adequate for us to provide quality, safe care.

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For these reasons, I respectfully request CMS revise the proposed 2007 and 2008 ambulatory surgical center payment system and increase the reimbursement percentage to at least 75%.

Sincerely,

Thomas Morrish, M.D.

Submitter : **Date: 11/01/2006**

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See Attachment

CMS-1506-P2-690-Attach-1.DOC

Ear, Nose & Throat Associates of Manatee, P.A.

701 Manatee Ave. W.
Bradenton, FL 34205
941-748-2455

October 31, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1506-P
P.O. Box 8011
Baltimore, MD 21244-1850

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Sincerely,

Agnes Nall, M.D.

Submitter : **Date: 11/01/2006**

Organization :

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See Attachment

CMS-1506-P2-691-Attach-1.DOC

#691

Gary M. Pullias, M.D., P.A.

2704 Manatee Ave. W.
Bradenton, FL 34205
941-748-8855

October 31, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1506-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Sir or Madam:

I am writing to comment on the proposed 2007 and 2008 changes to the ambulatory surgical center payment system. I would like to make sure that all Medicare beneficiaries have access to ambulatory surgical centers (ASCs). I am hoping that CMS will broadly interpret the budget neutrality provision enacted by Congress. I feel that offering to reimburse ASCs 62% of the hospital outpatient department (HOPD) fee schedule is simply not adequate for us to provide quality, safe care.

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For these reasons, I respectfully request CMS revise the proposed 2007 and 2008 ambulatory surgical center payment system and increase the reimbursement percentage to at least 75%.

Sincerely,

Gary M. Pullias, M.D.

Submitter : Carol Watson **Date:** 11/01/2006

Organization : Nueterra Healthcare

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

GENERAL

see attached

CMS-1506-P2-692-Attach-1.DOC

#692

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1506-P - Medicare Program; the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Ms. Norwalk:

I am writing regarding the proposed payment changes for Ambulatory Surgery Centers. I work for Nueterra Healthcare, a management company for ASCs. Through our affiliated centers, we serve thousands of Medicare recipients each year. We are very concerned that the changes, as currently proposed by CMS will have a detrimental affect on ASCs and the Medicare program.

Given the outdated cost data and crude payment categories underlying the current ASC system, we welcome the opportunity to link the ASC and hospital outpatient department (HOPD) payment systems. Although the HOPD payment system is imperfect, it represents the best proxy for the relative cost of procedures performed in the ASC.

In the comments to follow, we focus on three basic principles:

- maximizing the alignment of the ASC and HOPD payment systems eliminate distortions between the payment systems that could inappropriately influence site of service selection,
- ensuring beneficiary access to a wide range of surgical procedures that can be safely and efficiently performed in the ASC, and
- establishing fair and reasonable payment rates to allow beneficiaries and the Medicare program to save money on procedures that can be safely performed at a lower cost in the ASC than the HOPD.

Alignment of ASC and HOPD Payment Policies

Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost data used to evaluate outpatient surgical services for Medicare beneficiaries. The benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law. While we appreciate the many ways in which the agency proposes to align the payment system, we are concerned that the linkage is incomplete and may lead to further distortions between the payment systems. Many policies applied to payments for hospital outpatient services were not extended to the ASC setting, and these inconsistencies undermine the appropriateness of the APC relative weights, create disparities in the relationship between the ASC and HOPD payment rates, and embed in the new payment system site of service incentives that will cost the taxpayer and the beneficiary more than necessary.

There are many components of the regulation where a more complete alignment of the ASC and HOPD payment systems is appropriate. Below is an overview of the major areas where further refinement of the proposed rule is warranted. These issues are discussed in greater detail under the relevant section heading in the text to follow.

- **Procedure list:** HOPDs are eligible for payment for any service not included on the inpatient only list. The CMS proposal would limit a physician's ability to determine appropriate site of service for a procedure excludes many surgical procedures appropriate for the ASC setting.

- **Treatment of unlisted codes:** Providers occasionally perform services or procedures for which CPT does not provide a specific code and therefore use an unlisted procedure code identify the service. HOPDs receive payment for such unlisted codes under OPPS; ASCs should also be eligible for payment of selected unlisted codes.

- **Different payment bundles:** Several of the policies for packaging ancillary and other procedure costs into the ASC payment bundle result in discrepancies between service costs represented in the APC relative weight. For example, when HOPDs perform services outside the surgical range that are not packaged, they receive additional payments for which ASCs should also be eligible.

- **Cap on office-based payments:** CMS proposes to cap payment for certain ASC procedures commonly performed in the office at the physician practice expense payment rate. No such limitation is applied to payments under the OPPS, presumably because the agency recognizes the cost of a procedure varies depending on the characteristics of the beneficiary and the resources available at the site of service. We likewise believe this cap is inappropriate for the ASC and should be omitted from the final regulation.

- **Different measures of inflation:** CMS updates the OPPS conversion factor for annual changes in inflation using the hospital market basket; however, the agency proposes to update ASC payments using the consumer price index for all urban consumers. The market basket is a better proxy for the inflationary pressures faced by ASCs, as it is the measure used by the agency to update payments to hospitals providing the same services.

- **Secondary rescaling of APC relative weights:** CMS applies a budget neutrality adjustment to the OPPS relative weight values after they are recalibrated with new cost data each year. The agency proposes a secondary recalibration of the relative weights before they are used by ASCs. This secondary recalibration will result in annual and potentially cumulative variation between ASC and HOPD payments without any evidence that the cost of providing services has further diverged between settings.

- **Non-application of HOPD policies to the ASC.** Over the years, CMS has implemented through statutory or administrative authority numerous policies to support services in the HOPD, including additional payment for high-cost outliers, transitional corridor and hold-harmless payments to rural and sole-community hospitals, and payments for new technologies. While not all of these policies are appropriate for the ASC, surgery centers should be eligible to receive new technology pass-through payments.

- **Use of different billing systems:** The HOPD and ASC use the UB-92 and CMS-1500, respectively, to submit claims to the government for services. Use of different forms prevents ASCs from documenting all the services provided to a Medicare beneficiary, therefore undermining the documentation of case mix differences between sites of service. Most commercial payors require

ASCs to submit claims using the UB-92, and the Medicare program should likewise align the payment system at the claim level.

Ensuring Beneficiaries' Access to Services

Ambulatory surgery centers are an important component of beneficiaries' access to surgical services. As innovations in science and technology have progressed, ASCs have demonstrated tremendous capacity to meet the growing need for outpatient surgical services. In some areas and specialties, ASCs are performing more than 50% of the volume for certain procedures. Sudden changes in payments for services can have a significant effect on Medicare beneficiaries' access to services predominantly performed in ASCs.

The implementation of the revised payment system proposed by Medicare will result in significant redistribution of payments for many specialties. Because ASCs are typically focused on a narrow spectrum of services that require similar equipment and physician expertise, they have a limited ability to respond to changes in the payment system other than to adjust their volume of Medicare patients. On the one hand, for procedures such as ophthalmology, there is a limited market for these services in the non-Medicare population. If the facility fee is insufficient to cover the cost of performing the procedure in an ASC, responding to the change may mean relocating their practice to the HOPD. Such a decision would increase expenditures for the government and the beneficiary. On the other hand, the demand for services such as diagnostic colonoscopies is extremely high in the non-Medicare population. If ASCs determine that the payment rates for such services are too low, they may be able to decrease the proportion of Medicare patients they see without reducing their total patient volume. In that case, beneficiaries may experience significant delays accessing important preventive services or treatment. Neither outcome is optimal for the beneficiary of the Medicare program.

Establishing Reasonable Reimbursement Rates

Medicare payment rates for ASC services have remained stagnant for nearly a decade. Over time, the industry has identified which services it can continue to offer to Medicare beneficiaries through reductions in cost and improvements in efficiency. In the Medicare Payment Advisory Commission's first review of ASC payments in 2003, ASCs were paid more than the HOPD for eight of the top ten procedures most frequently performed in the ASC. One suggestion by the commission was that services migrated to the ASC because the payment rate was higher than the HOPD. However, a multi-year payment freeze on ASC services has turned the tables and now the HOPD rate in 2007 will be higher (or the same) for eight of the same ten ASC procedures. The continued growth of ASCs during the payment freeze is a strong testament to their ability to improve their efficiency and the preference of physicians and beneficiaries for an alternative to the hospital outpatient surgical environment.

The impact of HOPD payments eclipsing the ASC rates has had the perverse effect of increasing the "cost" of the budget neutrality requirement imposed by the Medicare Modernization Act on the future conversion factor for ASC payments. The Lewin Group estimates that the inflation updates applied to the HOPD rates since passage of the MMA account for 40 percent of the discount required to achieve budget neutrality under the agency's proposed rule. This, combined with the agency's narrow interpretation of budget neutrality, produce an unacceptably low conversion factor for ASC payments.

- Budget Neutrality: Adopt an expansive, realistic interpretation of budget neutrality. The new payment system and the expansion of the ASC list will result in migration of services from one site of service setting to another. CMS has the legal authority and the fiduciary responsibility to examine the

consequences of the new ASC payment system on all sites of care – the physician office, ASCs, and HOPD.

- ASCs should comment on the possible negative effect on access to services, since the methodology proposed results in ASC payments equaling only 62% of HOPD.

- By setting rates this low, CMS would force doctors to move cases to the more expensive hospital setting, increasing the amount of money paid by Medicare beneficiaries and the government. Rather than paying ASCs a set percentage of HOPD rates, the proposed rule establishes a complicated formula to link ASC payment to HOPD payment but does not link payment in a uniform manner. This will impede Medicare beneficiaries' ability to understand their real costs in alternative settings. In the words of President Bush, Medicare beneficiaries need to be able to make "apples to apples" comparisons in order to increase transparency in the health care sector.

- CMS failed to include on the procedure list many higher complexity services that have for years been safely and effectively performed in ASCs throughout the country. By not creating a truly exclusionary list, CMS is losing an opportunity to increase patient choice and rely on the clinical judgment of the surgeon.

In conclusion, I am asking for a reconsideration of many of the elements of the proposed changes as outlined above. Truly aligning the ASC payment system with that of the HOPDs is the most logical, fair and best policy approach to benefit the Medicare program and those served by the program. Should you have any questions regarding any of the issues in this letter, do not hesitate to contact me. My e-mail is cwatson@nueterra.com, my phone number is 913-387-0561, and my mailing address is 11221 Roe Ave., Suite 320, Leawood, KS 66211.

Sincerely,

Carol Watson

Submitter : Mr. Christopher Porter **Date:** 11/01/2006

Organization : Davita

Category : Health Care Professional or Association

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I support CMS practice of re-examining its policies as technology improves and practice patterns change, especially when supported by recommendations made by the Medicare Payment Advisory Commission (MedPAC) in their March 2004 report to Congress. The report concludes that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from the approved list.

Please support patient choice! There is clear scientific evidence that vascular access procedures are safe and can be performed in Ambulatory Surgical Center setting, and more importantly, patients are extremely satisfied with having the option to secure vascular access repair and maintenance care in an outpatient setting. Further, the inclusion of angioplasty codes in the ASC setting would support CMS Fistula First initiative by permitting a full range of vascular access procedures to be performed in an ASC setting, a less expensive and more accessible option than the current prevalent hospital setting.

Please treat End Stage Renal Disease patients fairly by ensuring all angioplasty codes, including CPT 35476 are allowed in the ASC setting.

Submitter : Mr. Christopher Porter **Date:** 11/01/2006

Organization : Davita

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Vascular access is one of the greatest sources of complications and cost for dialysis patients. Why, because America uses more surgical grafts and catheters for vascular access than the rest of the developed world, even though there is substantial evidence that they impose higher initial and maintenance costs, lead to greater clinical complications, and result in higher mortality than arterio-venous (AV) fistulae.

The inclusion of CPT codes 35475, 35476, 36205 and 37206 to the list of Medicare approved ambulatory surgical center (ASC) procedures would provide Medicare the opportunity to reduce the cost of, and promote quality outcomes for, end-stage renal disease (ESRD) patients through more thoughtful reimbursement and regulation of vascular access procedures.

Submitter :

Date: 11/01/2006

Organization :

Category : Ambulatory Surgical Center

Issue Areas/Comments

CY 2008 ASC Impact

CY 2008 ASC Impact

See Attachment

CMS-1506-P2-695-Attach-1.DOC

#695-

Rosabella Shek, M.D.

5857B 21st Avenue West
Bradenton, FL 34209
941-761-2666

October 31, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1506-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Sir or Madam:

I am writing to comment on the proposed 2007 and 2008 changes to the ambulatory surgical center payment system. I would like to make sure that all Medicare beneficiaries have access to ambulatory surgical centers (ASCs). I am hoping that CMS will broadly interpret the budget neutrality provision enacted by Congress. I feel that offering to reimburse ASCs 62% of the hospital outpatient department (HOPD) fee schedule is simply not adequate for us to provide quality, safe care.

I also feel the ASC list reform proposed by CMS is too limited. I hope that CMS will expand the ASC list of procedures to include any and all procedures that can be performed in a HOPD. CMS should exclude only those procedures that are on the inpatient only list.

ASC reimbursements should be updated based upon the hospital market basket because this more appropriately reflects inflation in providing surgical services than does the consumer price index. I feel the same relative weights should be used in ASCs and hospital outpatient departments.

Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. I believe that the benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law.

For these reasons, I respectfully request CMS revise the proposed 2007 and 2008 ambulatory surgical center payment system and increase the reimbursement percentage to at least 75%.

Sincerely,

Rosabella Shek, M.D.

Submitter : Ms. Karen Kelly **Date:** 11/01/2006

Organization : Surgery Center of Gilbert

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Coinsurance

ASC Coinsurance

ASC Coinsurance (Section XVIII.C.9)
We support retaining the Medicare beneficiary coinsurance for ASC services at 20 percent. For Medicare beneficiaries, lower coinsurance obligations will continue to be a significant advantage for choosing an ASC to meet their surgical needs. Beneficiaries will save significant dollars each year under the revised ASC payment system because ASC payments will in all cases be lower than the 20-40 percent HOPD coinsurance rates allowed under the OPPS.

ASC Conversion Factor

ASC Conversion Factor

ASC Conversion Factor (Section XVIII.C.11)
62 % conversion factor is unacceptable and often does not cover the cost of the procedure. We understand that budget neutrality is mandated in the MMA of 2003; however, we believe that CMS made assumptions in order to reach budget neutrality with which we differ, most especially the migration of cases from and to the ASC. The ASC industry has worked together with our physicians and established a migration model that is being provided to CMS along with the data in an industry comment letter. We encourage CMS to accept this industry model.

ASC Office-Based Procedures

ASC Office-Based Procedures

ASC Office-Based Procedures (Section XVIII.B.3)
We support CMS s proposal to extend the new ASC payment system to cover procedures that are commonly performed in physician offices. While physicians may safely perform many procedures on healthy Medicare beneficiaries in the office setting, sicker beneficiaries may require the additional infrastructure and safeguards of an ASC to maximize the probability of a good clinical outcome. In other words, for a given procedure, the appropriate site of service is dependent on the individual patient and his specific condition.

ASC Payable Procedures

ASC Payable Procedures

ASC Payable Procedures (Section XVIII.B.1)
We support CMS s decision to adopt MedPAC s recommendation from 2004 to replace the current inclusive list of ASC-covered procedures with an exclusionary list of procedures that would not be covered in ASCs based on two clinical criteria: (i) beneficiary safety; and (ii) the need for an overnight stay. However, the ASC list reform proposed by CMS is too limited. CMS should expand the ASC list of procedures to include any and all procedures that can be performed in an HOPD. CMS should exclude only those procedures that are on the inpatient only list and follow the state regulations for overnight stays.

ASC Phase In

ASC Phase In

ASC Phase-In (Section XVIII.C.10)
Given the size of the payment cuts contemplated under the proposed rule for certain procedures and specialties; especially GI, pain and ophthalmology, one year does not provide adequate time to adjust to the changes. Thus, we believe the new system should be phased-in over several years.

ASC Ratesetting

ASC Ratesetting

ASC Ratesetting (Section XVIII.C.2); ASC Packaging (Section XVIII.C.3); ASC Payment for Office-Based Procedures (Section XVIII.C.5); ASC Multiple Procedure Discounting (Section XVIII.C.6); ASC Wage Index (Section XVIII.C.7); ASC Inflation (Section XVIII.C.8)
We urge CMS to maximize alignment of the ASC and HOPD payment systems by adopting in the final rule the same packaging policies, the same payment caps for office-based procedures, the same multiple procedure discounts, the same wage index adjustments and the same inflation updates for ASCs and HOPDs.. These facilities exist in the same communities and often in partnership with the community hospital. Aligning the payment systems for ASCs and hospital outpatient departments will improve the transparency of cost and quality data used to evaluate outpatient surgical services for Medicare beneficiaries. We believe that the benefits to the taxpayer and the Medicare consumer will be maximized by aligning the payment policies to the greatest extent permitted under the law.

ASC Unlisted Procedures

ASC Unlisted Procedures

ASC Unlisted Procedures (Section XVIII.B.2)
At a minimum, when all the specific codes in a given section of CPT are eligible for payment under the revised ASC payment system, the associated unlisted

code also should be eligible for payment.

ASC Updates

ASC Updates

ASC Updates (Section XVIII.C.12)
We are pleased that CMS is committing to annual updates of the new ASC payment system, and agree it makes sense to do that conjunction with the OPPS update cycle so as to help further advance transparency between the two systems. Regular, predictable and timely updates will promote beneficiary access to ASCs as changes in clinical practice and innovations in technology continue to expand the scope of services that can be safely performed on an outpatient basis.

Submitter : Diana Geoghegan **Date:** 11/01/2006

Organization : HealthSouth Surgery Center of Belleville

Category : Ambulatory Surgical Center

Issue Areas/Comments

ASC Payable Procedures

ASC Payable Procedures

I am writing to you on behalf of the 29 surgeons and 13 employees of HealthSouth Surgery Center of Belleville regarding the proposed rule for a new ambulatory surgery center payment system.

In the proposed rule, CMS estimates that ASCs should be paid only 62% of HOPD for providing the identical outpatient surgical services. That low payment rate will result in significant cuts to a number of important, commonly performed services in ASCs including GI and ophthalmology. The Medicare program is saving money every time we perform one of these cases each year.

In addition this facility also provides the community with an alternative for cataract surgery providing over 396 surgeries per year. CMS can help Medicare and beneficiaries save money by making ASCs a viable, competitive alternative to outpatient hospitals by fixing the following problems in the proposed rule.

1. Adopt an expansive, realistic interpretation of budget neutrality that examines total Medicare spending on outpatient surgery. It is clear that the new payment system and the expansion of the ASC list will result in migration of services from one site of service setting to another. CMS has the legal authority and the fiduciary responsibility to examine the consequences of the new ASC payment system on all sites of care the physician office, ASCs, and HOPD.

2. Create a truly parallel system to HOPD in all aspects. The CMS proposed rule continues to treat HOPD and ASCs differently in certain key respects. These differences should be eliminated and ASCs and HOPD payments made on the same basis. Otherwise, many procedures that could be safely performed in an ASC more conveniently for patients and at less cost to the Medicare program will not be available because payments will remain below cost.

3. Do not widen the gap between HOPD and ASC payments over time. ASCs confront the identical inflationary pressures as hospitals hiring and retaining qualified OR nurses, purchasing medical supplies and the like. Yet CMS has proposed updating ASC payments by the consumer price index, a general measure of inflation of the economy rather than the hospital market basket update. This will result in a full percentage differential each year. Over time, the disparity in payments will create deeper divisions between prices paid in the HOPD and the ASC without any evidence that different payment rates are warranted.

Thank you in advance for your consideration of the comments above and the effect the proposed rule may have on our Ambulatory Surgery Center in St. Clair county Illinois. We appreciate the opportunity to help you understand our business and the cost savings we are able to provide to the Medicare program and our patients, the Medicare beneficiaries.

Sincerely,

Diana Geoghegan,
Administrator